

# CAMPER/STAFF HEALTH FORM

## INSTRUCTIONS

**PART 1** of this form must be filled out and signed by the minor child's parent/guardian or the adult staff person.

**PART 2** must be filled out and signed by a licensed health care provider (MD/APRN/PA). The Required Physical Exam must be completed within 2 years prior to the first day of camp.

**Once both parts are completed, they must be returned together to the camp office by the first week of June. If this individual will require medication at camp, you must fill out a medication authorization form. This form is available for download on our website or we can fax or email it to you as well.**



## **PART 1—to be filled out by minor child's parent/guardian or by adult staff member**

Full Name \_\_\_\_\_ **Check one: CAMPER**  **CIT**  **STAFF**

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade Entering in Sept \_\_\_\_\_ Gender \_\_\_\_\_

1st Custodial Parent Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

2nd Custodial Parent Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

### **Emergency Contact (other than Parents/Guardians listed above)**

Contact Full Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

## **CURRENT HEALTH DATA**

List specific allergies and treatment \_\_\_\_\_

Dietary restrictions or needs \_\_\_\_\_

Illnesses and medical treatment \_\_\_\_\_

Other special needs—physical, mental or psychological \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Regular Physician \_\_\_\_\_ Phone \_\_\_\_\_

Check "No" if you do NOT want HMDC staff to apply sunscreen to your child. No \_\_\_\_\_

The health history in Part 1 is correct so far as I know, and my child has permission to engage in all camp activities except as noted. **AUTHORIZATION FOR TREATMENT:** I give permission for my child to be treated in accordance with the standing orders as signed by the camp Physician. In the event that I cannot be reached in an emergency, I give permission for my child to be transported to a medical facility for treatment.

**SIGN HERE**

\_\_\_\_\_  
Signature of camper parent or guardian or adult staff person

\_\_\_\_\_  
Date

# CAMPER/STAFF HEALTH FORM—High Meadow Day Camp

**PART 2—to be filled out and signed by a licensed health care provider (MD/APRN/PA)**

Full Name of Camper or Staff Member \_\_\_\_\_

Date of most recent exam \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

After examination and my review of this individual's health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below:

Any restriction of activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any dietary restrictions or needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any allergies or additional health information: \_\_\_\_\_

\_\_\_\_\_

This individual is up-to-date on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	YES	NO		YES	NO
MMR			Hepatitis A & B		
HIB			Diphtheria		
Meningococcal			Pertussis		
Chickenpox			Polio		
Tetanus ( <b>Date of:</b> )			Pneumococcal		

***Licensed Health Care Provider's Signature (MD/APRN/PA)***

\_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Part 1 must be completed and signed, then Part 2 must be completed and signed by a licensed health care provider. Both parts must be sent together to the camp office by the first week of June.**

**High Meadow Day Camp  
14 Lindsay Circle  
North Granby, CT 06060**

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